235 State Street
St Croix Falls, WI 54024
715-483-3261
www.saintcroixhealth.org

Dear Patient,

We are pleased you have requested materials for our Financial Assistance Program.

The approval for our financial assistance program is determined based on income guidelines, family size and eligibility for state and federal health coverage.

As stated in our Financial Assistance policy, the program assists individuals with service dates that go back 240 days from the date a **"completed"** application is submitted and go forward for 12 months, so long as there are no changes to income and/or insurance coverage and/or family size.

If you wish to apply, please return the attached application, along with all necessary documentation within 30 days. Your submission is marked as complete on the date we receive the required paperwork in the attached instruction sheet, plus your application. If you need assistance completing this application, please call a Patient Financial Counselor at (715) 483-0475 or 1-800-828-3627 x 2475 Monday through Friday 8:00 am to 4:30 pm.

Our Financial Assistance Program is designed exclusively for the Hospital and Clinics of St Croix Health. Not all services provided by our medical centers are eligible as stated in our financial assistance policy. The program is intended to ease financial burden on a short-term basis and is not created as an alternative to health insurance.

Thank you for choosing St. Croix Health. It is our privilege to help you manage your health care.

Sincerely,

Michael Youso
Chief Executive Officer

Our *Financial Assistance* policy is available at www.saintcroixhealth.org or you may request a copy at any St Croix Health facility at the registration desk, emergency department or by calling a financial counselor at 715-483-0475.

PLAIN LANGUAGE SUMMARY

St. Croix Health's **Financial Assistance Policy (FAP)** assists with emergent, inpatient and outpatient medically necessary expenses and is available for those who meet eligibility criteria.

WHO CAN APPLY

All patients/guarantors can apply for financial assistance. This Policy provides discounted care for medically necessary healthcare for those who have:

- Submitted a complete financial assistance application.
- Income within the guidelines. See table below.
- Exhausted all other payment options and insurability.

Patient Financial Counselors will assist patients, who do not have insurance, in applying for Medicaid (MN and WI), MNSure, or Federal Insurance Exchange (Marketplace).

Persons in Family/ Household	250% Poverty Guideline (Annual income)
1	$36,450
2	$49,300
3	$62,150
4	$75,000
5	$87,850
6	$100,700
7	$113,550
8	$126,400

For Family/Households with more than 8 persons, add $12,850 for each additional person.

HOW TO APPLY

Ask or call a **Patient Financial Counselor at 715-483-0475 or toll free at 1-800-828-3627 ext. 2475**
Monday –Friday 8 am to 4:30 pm
Go to http:// www.saintcroixhealth.org

You can apply at St. Croix Health's Clinics:

- St. Croix Health clinic and hospital
  235 State Street
  St. Croix Falls, WI 54024
- Frederic Clinic
  205 Oak Street West
  Frederic, WI 54837
- Webster Clinic
  26425 Lakeland Ave So
  Webster, WI 54893
- Lindstrom Clinic
  12375 Lindstrom Lane
  Lindstrom, MN 55045
- Unity Clinic
  1504 190th Street
  Balsam Lake, WI 54810

FOR FREE COPIES OF THE POLICY AND APPLICATION AND/OR HELP

- A free copy of the policy and application is available at the Emergency Department, Registration staff at all facilities, Patient Financial Counselors or at our website: www.saintcroixhealth.org

Payment plan arrangements can be made on all outstanding accounts regardless of financial assistance qualifications. All accounts need to be in a formal and approved payment plan to keep in good standing.

FINANCIAL ASSISTANCE APPLICATION
INSTRUCTIONS & REQUIREMENTS

- Completed and signed application.
- Most recent Federal Tax Return copy including self-employment pages ***(Applicant for Financial Assistance must be the individual who claims you as a dependent on their federal tax return)***.
- Complete an application for Medical Assistance (WI & MN residents) and provide us with all pages of the approval or rejection letter

  Wisconsin Residents: To apply online, go to ACCESS.wi.gov and click on Apply for Benefits. ACCESS is also the fastest and easiest way to apply for all forms of Badger Care Plus.
  By Phone: 1-888-283-0012 Great Rivers Consortium

  Minnesota Residents: To apply online, go to MNSURE.org and click on Medical Assistance or MinnesotaCare By Phone: 855-366-7873

  Minnesota Residents receiving social security benefits: contact your local county human services office and apply for MN Medicaid.

- Income Verification for all household members-Examples include:
  - Pay check stubs with year-to-date earnings (3 most recent)
  - Annual statement of Social Security benefits
  - Statement of income from retirement and/or pension benefits (if applicable)
  - Unemployment benefits and/or short- or long-term disability (if applicable)
  - Bank Statements to support income (if applicable)
  - Proof of year-to-date child support or alimony payments (if applicable)

Application Deadline: Applicants will be given 30 days to complete the Financial Assistance Application and provide requested documentation

Submit application by:

HAND DELIVER: To any of our Patient Financial Counselors at any of our facilities.

MAIL TO: St. Croix Health Attn: Patient Financial Counselors
235 State Street
St. Croix Falls, WI 54024

FAX TO: 715-483-0505 Attn: Patient Financial Counselors

QUESTIONS: Patient Financial Counselors can be reached 715-483-0475

St Croix Health reserves the right to request additional information to determine eligibility

St. Croix HEALTH

FINANCIAL ASSISTANCE APPLICATION

1. Applicant			
Name:	Date of Birth:		Phone:
Address:			
City:	State:	Zip:	
Social Security #:			
Spouse's Name:	Date of Birth:		Phone:

2. Dependents		
Name:	Date of Birth:	Relationship:
Name:		
Name:		
Name:		

3. Monthly Income	Applicant	Spouse
Wages	$	$
Self-employment	$	$
Public assistance	$	$
Child Support/alimony	$	$
Pension/dividends	$	$
Unemployment	$	$
Social Security and Disability	$	$
Veterans' payments	$	$
Tribal Income	$	$
Tips/Commission	$	$
Income from estates/ trusts	$	$
Educational assistance	$	$
Other income	$	$

4. Health Insurance Coverage		
Name/Household member	Insurance	Policy #

St. Croix HEALTH

FINANCIAL ASSISTANCE APPLICATION

5. Applicant's Employment:_____

Hourly wage?_____Hours per week_____

Employment:_____

Hourly wage?_____Hours per week_____

6. Spouse's Employment:_____

Hourly wage?_____Hours per week_____

Employment:_____

Hourly wage?_____Hours per week_____

7. If you did not file a recent tax return, please explain:_____

_____

8. In relation to your medical bills, do you have a lawsuit or insurance claim because of an accident or injury? _____(Yes or no) or Spouse _____(Yes or no)

Name/phone of your attorney_____

9. In relation to your medical bills, do you have worker's compensation case?

___(Yes or no) or Spouse _____(Yes or no)

Insurance carrier/attorney_____

Insurance carrier/attorney_____

10. In relation to your medical bills, do you have motor vehicle case?

___(Yes or no) or Spouse _____(Yes or no)

Insurance carrier/attorney_____

Insurance carrier/attorney_____

11. In relation to your medical bills, do you have third-party liability case?

___(Yes or no) or Spouse _____(Yes or no)

Insurance carrier/attorney_____

Insurance carrier/attorney_____

I certify that the above information is true and correct. I will notify St. Croix Health's Patient Financial Counselors at 715-483-0475 or toll free at 1-800-828-3627 ext. 2475 of any changes in the information provided on this form. I also understand that my application is subject to the guidelines of St. Croix Health's Financial Assistance Policy.

I understand that the information submitted concerning my annual income and family size is subject to verification by St. Croix Health. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

I hereby authorize St. Croix Health to review federal and state records of employment and income history,

Signature:_____ Date:_____